

**Virginia Managed Care
Performance Report
2003 - 2004**

December 2004

<http://www.dmas.virginia.gov/mc-home.htm>

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Purpose and Introduction to Virginia's Managed Care Programs



This is the third installment in a series of annual managed care performance reports. This report analyzes Fiscal Year 2003 (July 1, 2002 through June 30, 2003) to Fiscal Year 2004 (July 1, 2003 through June 30, 2004). The report provides synopsis of how DMAS and the managed care organizations have supported Governor Mark Warner's commitment to improved pregnancy and maternity outcomes, child health, and increased provider reimbursement rates.

The Virginia Department of Medical Assistance Services (DMAS) provides Medicaid to individuals through four programs: **Fee-for-Service (FFS)**, the standard Medicaid program; **MEDALLION**, a Primary Care Case Management (PCCM) program utilizing contracted primary care providers; **Medallion II**, a program utilizing contracted managed care organizations (MCO); and Home-Based and Community Waivers. DMAS also administers the State Child Health Insurance Program (SCHIP) called the **Family Access to Medical Insurance Security (FAMIS)**. Although FAMIS is not a Medicaid program, it is provided through the FFS, PCCM, and MCO delivery systems.

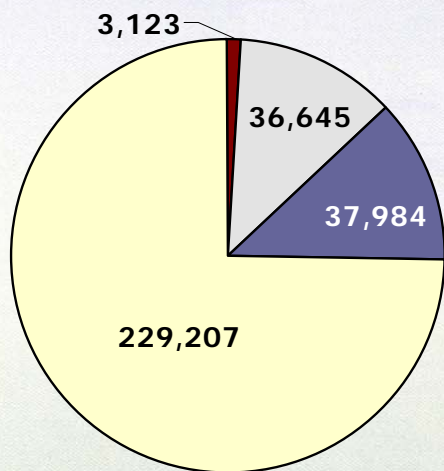
The **DMAS managed care programs primarily serve four groups**: FAMIS Plus (Medicaid children), FAMIS, pregnant women, and individuals who receive Supplemental Security Insurance. Approximately 2,000 primary care providers are enrolled in MEDALLION, and seven MCOs participate in Medallion II and FAMIS: Southern Health-Care/Met, Optima Family Care (formally known as Sentara Family Care), Anthem HealthKeepers Plus by HealthKeepers, Anthem HealthKeepers Plus by Peninsula Health Care, Anthem HealthKeepers Plus by Priority Health Care, UniCare Health Plan of Virginia, and Virginia Premier Health Plan.

Currently, FAMIS, Medicaid/FAMIS Plus FFS, MEDALLION and Medallion II are operating throughout the Commonwealth. As a result of the Governor's commitment to child health insurance coverage, **child health enrollment has now reached 383,308***.

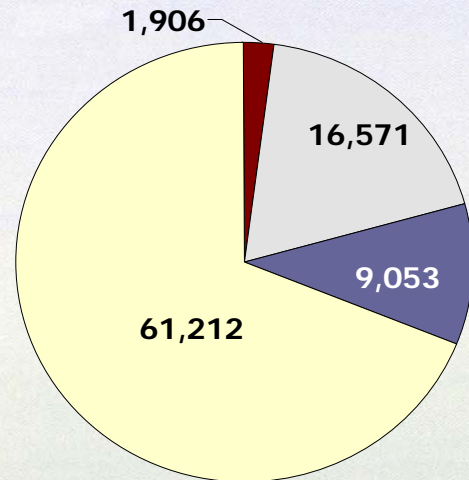
* July 1, 2004

Managed Care Enrollment as of July 1, 2004 (Figure 1.)

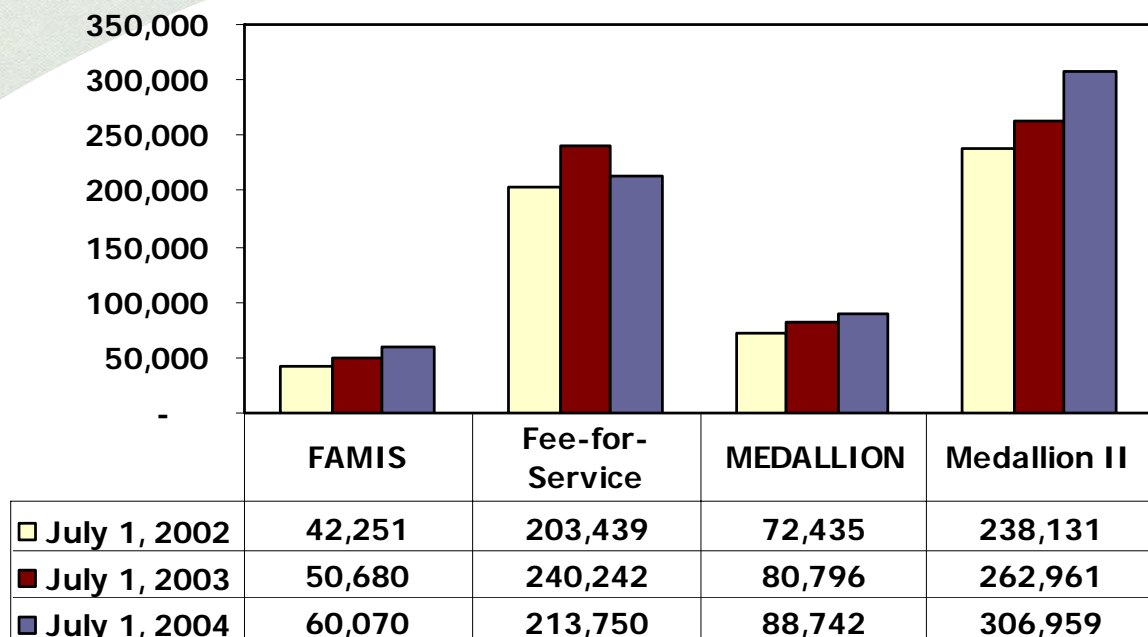
Who is enrolled in Medicaid Medallion II?



Who is enrolled in Medicaid MEDALLION?



■ Aged □ Blind/Disabled ■ TANF (Adult) ■ TANF (Child)



Internal Report Card

Areas targeted for continuous quality improvement in the 2003 Performance Report were prenatal care and birth outcomes, immunization rates, dental access, "best practices" implementations for the MEDALLION program, encounter data, and operations. **DMAS' Internal Report Card recognizes the successes, near successes, and missed targets in the past year.**



Increased Child Enrollment - The Governor has made a clear statement that prenatal and child health is one of his top priorities to create a healthy Virginia. **As a result of Governor Warner's directive and FAMIS outreach, over 103,000 children were enrolled in either FAMIS or Medicaid.**

FAMIS Outreach - Virginia's SCHIP program was featured by the National Academy of State Health Policy (NASHP) in a report titled "SCHIP Changes in a Difficult Budget Climate: A Three-State Site Visit Report" (www.nashp.org). NASHP spent two days with SCHIP staff, consumer advocates, health plan representatives, and lawmakers to discuss Virginia's rapid enrollment increases and the recent policy changes that helped support this growth.

Immunizations: For the first time, the Commonwealth surpassed its very ambitious immunization compliance target of 85%. During this reporting period, Delmarva, an external quality review organization, reported the immunization series (4:3:1) for children at 24 months was 89%.

Pregnancy outcomes - DMAS is working with the contracted health plans and other state agencies to improve prenatal care and birth outcomes. There has been one notable success. **Optima's distinctive "Partners in Pregnancy Program" received the DMAA Award in Orlando at the DMAA (Disease Management Association of America) 6th Annual Leadership Forum in October 2004.** The award recognizes the Best Disease Management Program in Medicaid. It is a peer-selected award by members of the DMAA designed to recognize organizations that have implemented disease management programs in their respective market segments (commercial MCO, PPO, Medicare, Medicaid, or the Military.) To be eligible for the award, a health organization must have demonstrated excellence in the design, development, implementation and operation of a disease management program with success demonstrated by favorable outcomes.

Encounter Data - DMAS has collaborated with the MCOs to gather encounter data in the new Medicaid Management Information System (MMIS). DMAS worked extensively with the MCOs and First Health Services to develop a reliable encounter database. Since May of 2004, DMAS has worked with MedStat, a healthcare information company, to complete an encounter data validation study. This study will prove highly beneficial in improving the encounter data for use in quality studies/improvement initiatives, as well as, for use in MCO rate setting.

Internal Report Card



Virginia Managed Care Performance Report 2002 to 2003 - Through the expert technical assistance at the Center for Health Care Strategies, this report received extensive exposure that benefited the State's Managed Care Organizations participating with Virginia Medicaid and FAMIS programs, and advocates collaborating to improve Virginia's Medicaid managed care programs. The report gained widespread media attention in its second year of publishing and was targeted for national magazine coverage. Other states took notice of the innovative approach to performance reporting that told Virginia's story by showcasing its successes and its failures.

Medicaid Payment Accuracy Measurement (PAM) Project – CMS selected DMAS' proposal for participation in the second year of the PAM project. CMS, in conjunction with The Lewin Group, a health care and human services consulting firm, and Delmarva, an external quality review organization, developed the CMS PAM model for estimating payment accuracy in both the Medicaid Fee-for-Service and managed care programs. The Managed Care Unit developed methodologies that incorporated PC-SAS programming and an internal Access database that were very well received by CMS, Lewin, and Delmarva representatives. These representatives promoted the internal database as an example that could be used by other states to promote efficiency and accuracy while researching complex Medicaid payments.

MCO Disease State Management Collaboration with FFS - The Department of Medical Assistance Services has implemented a one-year pilot Disease State Management project in collaboration with Anthem on June 1, 2004. The Healthy Returns Program, which is administered by a subsidiary of Anthem, Health Management Corporation, targets individuals enrolled in Medicaid FFS diagnosed with Congestive Heart Failure and/or Coronary Artery Disease. Anthem provided this program free of charge to DMAS. The goal of this project is to measure the impact on health status and medical costs for those enrolled in the program with the hopes of obtaining measurable, positive results. The strategy employed by the program to improve health while decreasing the overall medical costs is to stratify the participating population by degree of risk and need and tailor an intervention to best meet their needs. The degree of intervention depends on the level of health risk as identified by the health assessment screening conducted by the Healthy Returns Program Team. Interventions vary in degree of intensity such as educational mailings for those determined low risk and telephonic nurse case manager support for those determined high risk. Additionally, case managers also communicate the health status and needs of the participant to the treating physician and assist in coordinating the delivery of care and social needs. Participation in the Healthy Returns is voluntary. The first quarterly report in September from the Healthy Management Program shows the program is being well received by the 1,581 participants and physicians.

Anthem Health Management Corporation's *Baby Benefits* maternity management program was the SILVER winner of the distinguished 2003 AAHP/Wyeth HERA Award. Acknowledging the program's positive impact, the HERA Award honors those who have made a difference in health care through improvement in women's' and children's health outcomes.

Internal Report Card



EPSDT - Each year the Department evaluates progress towards screening participation using Early and Periodic Screening, Diagnosis and Treatment (EPSDT) criteria outlined by CMS. All FAMIS Plus children are considered in the evaluation. EPSDT services also includes other medically necessary health care, diagnostic services, treatment and other measures listed in the Federal Medicaid statute, to correct and ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not they are covered in the state Medicaid plan.

As part of the on-going activities related to the EPSDT program, the Department developed EPSDT letters to remind the member that EPSDT services are available, at no cost, and how to access those services. Enrolled households with a child under the age of 21, including children enrolled in the MCOs, received the letter. All children enrolled in the DMAS waivers and the Mental Retardation Waiver received letters as well. The letters were translated into Spanish, which was printed on the backs of the letters. The Department also developed an automatic system generated EPSDT letter to be sent within a child's first week of enrollment into Medicaid. In December 2004, DMAS started mailing postcards, signed by Governor Mark R. Warner, to children in their birth month reminding their parents/caregivers to keep up with screenings and immunizations.

The recent implementation of "ClaimCheck" billing system resulted in the Department being made aware that there was conflict and confusion on EPSDT between the manual, training module, and the billing system. DMAS reviewed various procedures related to EPSDT medical screening and addressed the issues in the multiple meetings with providers and a special EPSDT training held in August 2004.

The Department revised the DSS Applicant Handbook to include more EPSDT information. This handbook is available to citizens interested in the Medicaid program. An Enrollee handbook is nearing completion, which will be distributed to all currently enrolled recipients and to new enrollees.



Dental Access – Even though the contracted health plans offered to pay charges to some dentists (estimated MCO payments to dentists in SFY 2004 were nearly \$28 million vs. FFS payments of slightly over \$13.4 million), the MCOs experienced consistent resistance by dental providers to provide services to their members. Consequently, DMAS had an increasing number of complaints regarding access to dental providers. DMAS worked with representatives from its Dental Advisory Committee and the Virginia Dental Association to improve dental access across the Commonwealth. As a result, all Medicaid and FAMIS dental services will be consolidated under a single administrative arrangement. A Dental manager has been hired and a Request for Proposal will be released for procurement of a dental benefits management company.

Reduced MCO Provider Network Coverage - Optima Family Care and Southern Health-Care/Net notified the Health Care Services Division that effective June 1, 2003 and September 1, 2003 respectively, they would be withdrawing from the City of Fredericksburg and the counties of King George, Spotsylvania, and Stafford. For these areas, the MCO Unit transitioned more than 400 FAMIS children to Anthem and Virginia Premier. Nearly 5,000 Medallion II recipients who were in Optima and Care/Net transitioned to FFS and have remained in FFS throughout this reporting period. It is anticipated that Anthem and Virginia Premier will establish a network of providers and hospitals and that a transition of these recipients back to managed care will occur by the end of 2004.

FAMIS and Medallion II Managed Care Organizations

Based on stability, growth, and external studies, **Virginia's Medicaid managed care program is one of the best in the country.** The health plans provide high quality health care in an integrated, comprehensive delivery system for those Medicaid recipients in managed care. Increasingly, representatives from Medicaid's managed care community are serving in advisory roles for new FFS program initiatives such as pharmacy and dental. Their direction has been beneficial in moving the state's program more in line with commercial practices. A chart of the seven MCOs that participate in the FAMIS and Medallion II programs is shown below. Four of Virginia's MCOs received an "Excellent" National Committee for Quality Assurance (NCQA) accreditation during SFY 2004.

Figure 2. Managed Care Coverage Area Map

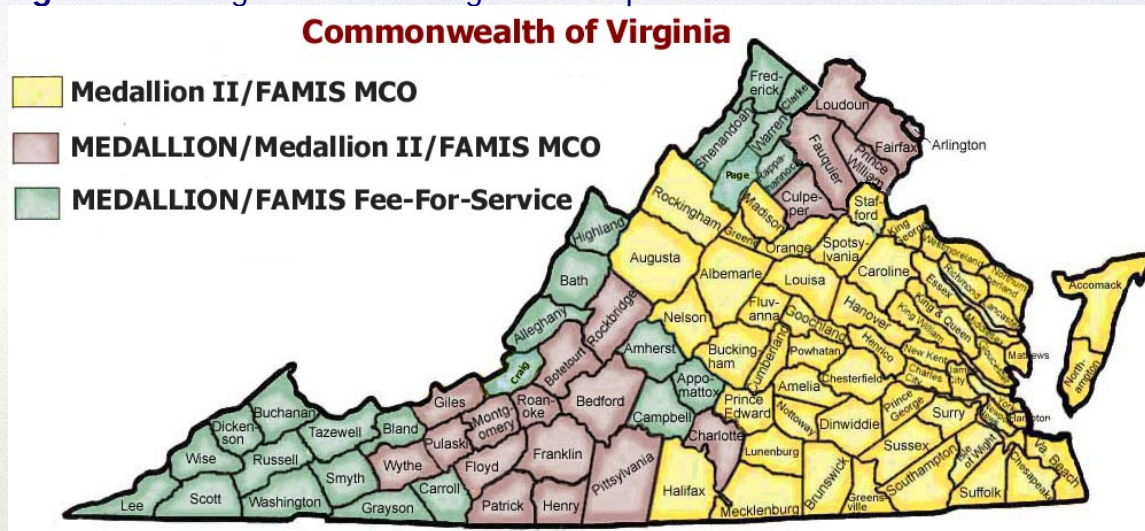


Figure 3. MCO Characteristics

Health Plan	Alternate Address and Web Address	Enrollees as of July 2004	Localities and Medallion II Start Date	Accreditation
Anthem Healthkeepers, Inc. Address: 2220 Edward Holland Drive Richmond, VA 23230	277 Bendix Road, Suite 100 Virginia Beach, VA 23452 Telephone: 1-800-901-0020 Website: http://www.anthem.com/	33,265	37 cities/counties Tidewater Central Virginia Regions Start Date: 01/01/1999	NCQA- Excellent Accreditation Status
Anthem Peninsula Health Care, Inc. Address: 2220 Edward Holland Drive Richmond, VA 23230	277 Bendix Road, Suite 100 Virginia Beach, VA 23452 Telephone: 1-800-901-0020 Website: http://www.anthem.com/	17,389	16 cities/counties Tidewater and Central Virginia Regions Start Date: 01/01/1996	NCQA- Excellent Accreditation Status
Anthem Priority Health Care, Inc. Address: 2220 Edward Holland Drive Richmond, VA 23230	277 Bendix Road, Suite 100 Virginia Beach, VA 23452 Telephone: 1-800-901-0020 Website: http://www.anthem.com/	22,683	9 cities/counties Tidewater and Central Virginia Regions Start Date: 01/01/1996	NCQA- Excellent Accreditation Status
CareNet-Administered by Southern Health Address: 9881 Mayland Drive Richmond, VA 23233 Telephone: 804-747-3700	Website: http://www.southernhealth.com	14,335	30 cities/counties Tidewater and Central Virginia Regions Start Date: 01/01/1999	NCQA- Commendable Accreditation Status
Optima Family Care- Administered by Optima Health Plan Address: 4417 Corporation Lane Virginia Beach, Virginia 23462 Telephone: 1-800-SENTARA	Website: http://www.optimahealth.com	98,134	69 cities/counties Tidewater, Central Virginia, Charlottesville, and Halifax Regions Start Date: 01/01/1996	NCQA- Excellent Accreditation Status
UNICARE Health Plan of Virginia Address: 241 South Van Dorn Street Alexandria, VA 22304 Telephone: 1-800-997-4765	Website: http://www.unicare.com/	34,202	19 cities/counties Northern Virginia and Charlottesville Regions Start Date: 12/01/2001	NCQA Health New Plan
Virginia Premier Health Plan Address: 600 E. Broad Street, Ste 400 Richmond, VA 23219-1800	213 S. Jefferson Street, Ste 1400 Roanoke, VA 24011 Telephone: 804-819-5151 Website: N/A	64,673	73 cities/counties Tidewater, Central Virginia, Charlottesville, and Roanoke Regions Start Date: 01/01/1996	JCAHO

Leading Virginia to Better Health

Executive Directive #2 – Medicaid is the primary payer for obstetrical services, and on average, pays for 35 to 40 percent of all deliveries or approximately 30,000 births each year in the Commonwealth. The Commonwealth of Virginia is facing a health care crisis because many women in rural areas have limited access to necessary obstetrical care. To address this situation, Governor Mark Warner signed Executive Directive #2 (ED2) that directed the Secretary of Health and Human Resources to convene and chair the Rural Obstetrical Services Work Group.

The Work Group issued an Interim Report on July 1, 2004. Based on recommendations in that report, the Governor provided emergency authority and funding, effective September 1, 2004, for DMAS to increase the Medicaid payment rates for outpatient Obstetrical and Gynecological services by 34 percent through the emergency regulation process.

The final report, issued on October 29, 2004, offered 27 recommendations across six policy areas including eligibility for services, reimbursement levels, medical malpractice, license/scope of practice, birth injury, and improving access to care. The four major recommendations included:

- Increasing the income standard for pregnant women to 200 percent of the federal poverty level (FPL). (The Governor's budget released on December 17, 2004 proposes an expansion to 175 percent of the FPL.);
- Increasing the physician fee schedule for OB/GYN and pediatric services and inpatient hospital payment rates for obstetrical-related services;
- Amending the Code of Virginia sections that relate to medical malpractice and possible interventions with respect to medical malpractice insurance that could improve access to and the provision of obstetrical care; and,
- Implementing, in one or more pilot sites, an alternative system of prenatal and obstetrical services in areas that are experiencing severe problems in accessing such care.

Potential future results from the activities of the Work Group include:

Eligibility – Virginia Medicaid currently covers pregnant women up to 133 percent of FPL and the Commonwealth has not yet elected to expand coverage to a higher income group through Medicaid. By increasing the income standard for pregnant women to 175 percent of FPL, women between 133 percent FPL and 175 percent FPL will be enrolled in SCHIP to leverage federal funds (66 percent federal share versus basic Medicaid program federal share of 50 percent.)

Malpractice – During the 2005 session of the General Assembly, it is likely that bills will be introduced to improve the status and affordability of medical malpractice insurance. These may include discussions of policy terms, closed claim reporting requirements, expansion of the utilization of the Tort Claims Act, coverage for part time or job share situations, and the possibility of a medical malpractice insurance premium subsidy.

Leading Virginia to Better Health

“No Wrong Door Policy” - Another recommendation from the ED2 proposes expanding its FAMIS Central Processing Unit to allow all pregnant women to have a centralized point of application and eligibility determination. DMAS is proposing a “No Wrong Door Policy.” Eligibility will be determined within 10 days of receipt of a completed application. DMAS is also working with the health department to create a process where the enrollment can be accepted electronically. This should increase the number of women who receive care in the first trimester and eliminate other policy barriers to enrollment. This also will assist the health departments and other clinic sources who are providing uninsured care. In addition, expanding eligibility to pregnant women will allow more of Virginia’s women the quality birth outcomes provided in the managed care organizations’ prenatal programs.

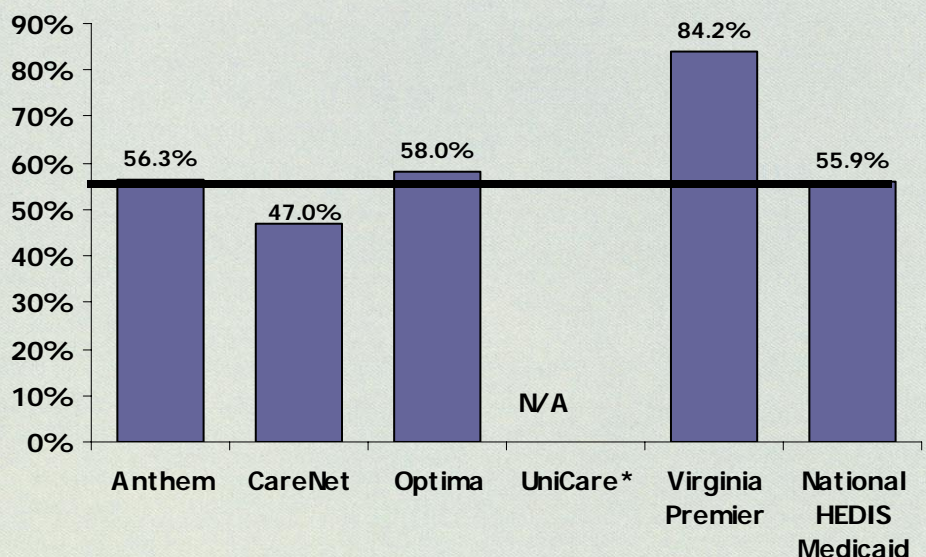
Pilot Projects - The current model for delivering obstetrical care to pregnant women in Virginia involves prenatal care with a local obstetrician or family physician and delivery at the local hospital. The convergence of multiple pressures, including the high cost of medical malpractice insurance, low reimbursement rates, and low volume has resulted in the loss of providers in rural areas. Through a well-coordinated matrix of health departments, birth centers, Level III Perinatal Centers, academic medical centers, and other hospitals, complete obstetrical access could be expanded to “stressed” areas in Virginia. The Virginia Department of Health will lead the implementation of these pilot projects to demonstrate the effectiveness of a new practice paradigm among obstetric providers designed to increase access to high quality pregnancy-related care.

Quality Assurance: Breast Cancer Screening

The Breast Cancer Screening rate estimates the percentage of women aged 52-69 years who had at least one mammogram within the past two years. Three Medallion II health plans’ 2003 HEDIS rates for breast cancer screening were close to reaching the National HEDIS Medicaid rate of 55.9%. **One of the MCOs dramatically exceeded the National HEDIS Medicaid rate with an impressive 84%.**

(*Please note: UniCare does not have a 2004 HEDIS rate for breast cancer screening because this measure requires at least two years of continuous enrollment.)

Figure 4. HEDIS 2004 Breast Cancer Screening Results by MCO



National and State Quality Improvement Initiatives

Throughout the operations of the FAMIS, MEDALLION, and Medallion II programs, DMAS has encouraged and sought out the involvement of various stakeholders in its planning and operations. **DMAS is increasingly seeking representatives from managed care organizations to participate in national and state quality improvement initiatives.** Their influence can be felt in committees that include providers from numerous arenas and representatives from various state agencies that play a role in serving Medicaid recipients such as the Virginia Department of Health (re: Title V -The Maternal and Child Health Program that was enacted as Title V of the Social Security Act as a health services safety net for all women and children); the Virginia Department of Social Services (re: enrollment and eligibility issues); the Virginia Department of Education (re: school health services); the Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services; and, advocates representing a broad range of interests, particularly the special needs populations. Several examples of collaborative efforts follow:

HRSA/MSU Collaborative to Reduce Racial and Ethnic Disparities in Health - The HRSA (Health Resources and Services Administration)/MSU (Michigan State University) Collaborative to Reduce Racial and Ethnic Disparities in Health is an on-going initiative focused on quality improvement which involves DMAS and two managed care plans, Optima Family Care and UniCare Health Plan of Virginia. Currently, the states that are participating in this nationwide collaborative project are Michigan, Montana, Texas, Oregon, Washington, and Virginia. The overall goal is for the participating states to identify and then work with their health plans to reduce racial and ethnic disparities in quality of care through quality improvement projects. Optima's health disparity quality project focuses on diabetes and UniCare's project focuses on asthma, both of which affect the African-American population. DMAS attended the Center for Health Care Strategies Purchasing Institute on Leveraging Data to Reduce Racial and Ethnic Disparities in November 2004. The goal of the CHCS meeting was for each State to create a project where they would look at racial disparity and track it through data.

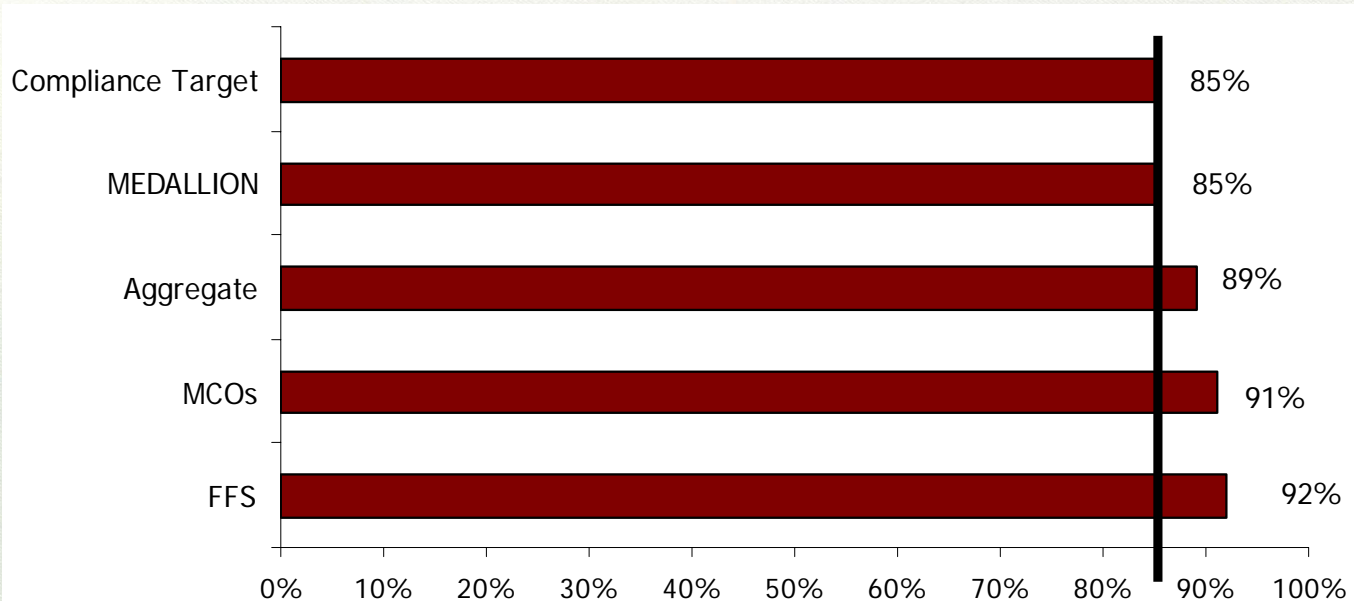
Virginia Premier was selected by the Center for Health Care Strategies (CHCS) in its national quality improvement initiative – Best Clinical and Administrative Practices (BCAP.) BCAP convenes leaders from health plans and states across the country to catalyze quality improvement advances in Medicaid managed care. One of 10 Medicaid plans chosen, Virginia Premier set an overall aim for 75 percent of identified providers to perform developmental screenings on high-risk members aged 0-3 as part of BCAP Enhancing Early Child Development in Medicaid Managed Care. Virginia Premier joins more than 110 health plans and primary care case management programs representing more than 13.5 million Medicaid beneficiaries across the country to develop realistic quality improvement initiatives and share best practices with a national network of health plans and states that may affect system-wide changes to improve the quality of Medicaid services.

Case Managers' Meetings - Case Managers' Meetings are conducted twice a year for a variety of stakeholders. Attendees represented health and social service workers, Medicaid contracted MCOs, Community Service Boards, and acute care hospitals. In October 2003, meetings were held in Newport News, Richmond, and Alexandria on the topic of Medicaid Home and Community Based Waivers. In June 2004, meetings on the Statewide Information and Referral (I&R) System were held in Newport News, Richmond, and Alexandria. In October 2004, meetings were held in Fairfax, Richmond, Newport News and Roanoke and the topics were the principles and coverage under EPSDT, as well as, the Family Planning Waiver.

Leading Virginia to Better Health: Immunization Compliance

Immunization Study. Immunization compliance is one of the Department's key performance indicators and its greatest accomplishment during this year. **For the first time, the state's fully completed immunization series (4:3:1) at 24 months was 89%. In addition, a rate of compliance for being up-to-date for all immunizations was 87%.**

Figure 5. 2003 Percent of Two-Year-Old Children Fully Immunized (4:3:1) (Source: Internal immunization study performed by Delmarva)



Leading Virginia to Better Health: Disease and Health Management

The MCOs are highly focused on various **disease and health management programs** in order to better the lives of their members in the communities. Such programs provide preventative care, timely health reminders for vaccinations/screenings, and valuable educational materials for members. Other programs include outreach to physicians, case management, and continued outreach efforts in “at-risk” populations. Each MCO has implemented unique programs specific to their members’ needs that promote good health and improve health outcomes. **Examples of three disease and health management programs that the MCOs offer that demonstrate quantitative results are as follows:**

Prenatal Programs

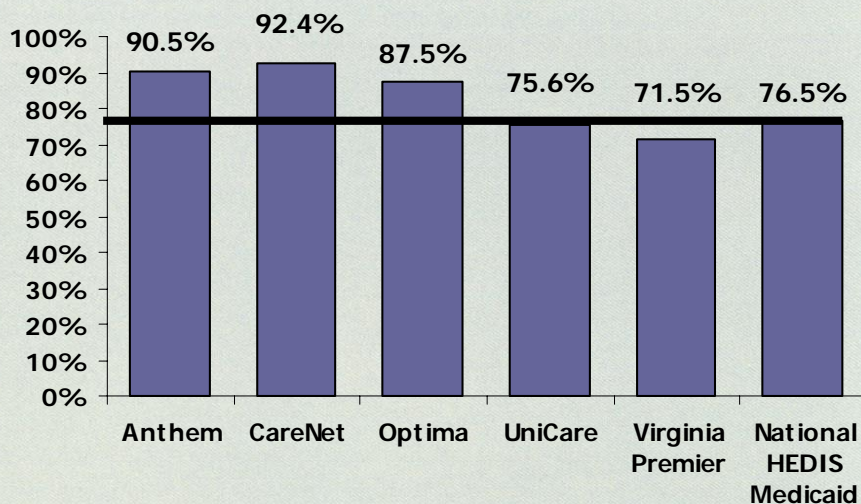
Prenatal care has three basic components: early and continuing risk assessment, health promotion, and medical and psychosocial follow-up. Providing this prenatal care can help reduce maternal mortality, morbidity, and fetal complications (e.g., pre-term birth, intrauterine growth retardation), and promote healthy growth and development. Virginia’s MCOs have developed programs that specifically address each of the three components of prenatal care.



The Health Plan Employer Data and Information Set (HEDIS®) definition for timeliness of prenatal care is as follows: The percentage of women who received a prenatal care visit as a member of the MCO in the first trimester of within 42 days of enrollment in the MCO. **HEDIS® rates for the timeliness of prenatal care were all above the National HEDIS® Medicaid rate of 70%, with the highest rate close to 86%.** The Medallion II health plans are displaying very positive results in this area, which means that members of these plans are receiving prenatal care in a timely and efficient manner.

UniCare’s 2003 HEDIS® rate for *Timeliness of Prenatal Care* was 71.06% and for *Postpartum Care* the rate was 50.46%. In 2004, UniCare’s reported HEDIS® rate for *Timeliness of Prenatal Care* was 75.69% and the rate for *Postpartum Care* was 53.24%, an increase of 4.63 and 2.78 percentage points from 2003 rates, respectively. Infant delivery outcomes for UniCare Medallion II members in 2004 compared to 2003 show improvement in the area of low birth weight (LBW = 1501g to 2499g) and normal birth weight (NBW= >2499g) deliveries. Specifically, in 2004 there were 3.49% low birth weight deliveries and 95.11% normal birth weight (NBW= >2499g) for UNICARE Medallion II members, whereas in 2003 there were 4.96% LBW deliveries and 93.98% NBW deliveries.

Figure 6. HEDIS 2004 Prenatal Care Timeliness by MCO



Leading Virginia to Better Health: Disease and Health Management

Diabetes Programs

According to the NCQA's "The State of Health Care Quality 2004" publication, diabetes is the sixth leading cause of death by disease in the United States. Diabetes can lead to long-term complications such as heart disease, blindness, kidney disease, and stroke. Several MCOs have recognized the importance of targeting quality programs to improve their clients' health outcomes.



In 2003, **UniCare** implemented a Diabetes Management Program (DMP) that was developed based on a population health model. The DMP combines condition management information with clinical support tools, member education, and case management for appropriate members.

UniCare's 2004 HEDIS® rate for the measure HbA1c Testing (which reflects a diabetic's average condition over a three-month period) was 82.46%. The national Medicaid rate for HbA1c Testing was 74.00%. Additionally, UniCare's HEDIS rate for the measure of LDL-C (low-density lipoprotein cholesterol) Screening in 2004 was 85.38%, exceeding the national Medicaid rate of 71.7%.

Optima's Diabetes Disease Management Program is open to all members with diabetes and is based on a two-pronged approach focused on educating members and practitioners. In an effort to identify members as early as possible, a variety of methods are utilized: the use of health risk appraisals, review of hospital admissions data, lab value review, coordination with case managers, claims code review, and physician referral. High-risk members receive additional targeted mailings and case management coordination. **Optima's Diabetes Program was awarded recognition for meeting the nation's Standards of Excellence by the American Diabetes Association.** Positive program outcomes were seen this year. **Hospital admissions for diabetes decreased by 7.1% in 2003 and emergency department visits for primary diabetes decreased by 14.3% in 2003.**

CareNet's Diabetes Disease Management Program applies evidence from research to provide the best care to members with diabetes. Members with diabetes receive intense education, targeted reminders and case management as needed, designed to encourage compliance with guidelines developed by the American Diabetes Association. In 2004, CareNet members will be eligible to participate in a program using diet and lifestyle counseling designed to encourage weight loss and better blood sugar control. There was improvement in every diabetes related HEDIS measure in 2003. In 2003, LDL levels improved by 22%. In addition, HbA1c testing, HbA1c control, and cholesterol checks all improved by 15%.

The **Anthem** Better PreparedSM Program fosters improved health of its managed members by better coordinating pharmacy utilization, physician services, and patient self-care, emphasizing increased adherence to behaviors associated with optimal health. **Priority's members with diabetes showed improvement on eight of the nine outcome measures. The most notable increases for this population were with home glucose monitoring, which increased to 55%, and the rate of retinal eye exams, which rose 51%. Nearly all (98%) members are compliant with diabetic medication, above the targeted level of 90%.** Testing rates were consistently higher for those targeted for high intensity management, demonstrating the benefit of more intensive intervention for these Medicaid members.

Leading Virginia to Better Health: Disease and Health Management

Asthma Programs

UniCare began implementation of the Asthma Management Program (AMP) in 2003. Through the AMP, members are offered resources and services (e.g. case management and pharmacy consultations) to help manage their asthma condition. The AMP actively engages member and physician participation to help improve health outcomes for asthmatics. The AMP includes: (1) partnerships with plan physicians to promote practice guidelines and provide patient specific information to the physician and (2) education to members on self-care and the importance of regular physician visits. Additionally, UniCare offers partnerships with pharmacists to provide educational consults upon dispensing asthma medications to UniCare members. **Comparatively, the 2004 UniCare HEDIS rate for the measure of *Appropriate Use of Asthma Medications* was 64.15%, which exceeded the national Medicaid rate of 62.8%.**

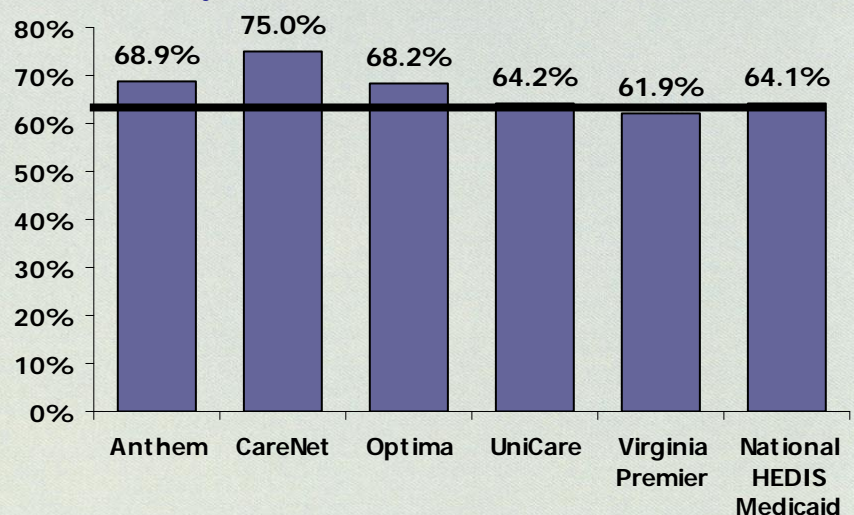


Optima's Asthma Disease Management Program was developed to educate both patients and practitioners about asthma health related issues and to assist in the management of this chronic disease. The Disease Management Program targets members identified as high risk and provides intensive education and follow up for these members. **Inpatient admissions for Optima's Medicaid members with asthma decreased 2% between 2002 and 2003. The medication ratio used to determine optimum use of rescue medication to preventative medication decreased from 1.87 in 2002 to 1.67 in 2003, a positive indicator of better prescribing practices for asthma medication.**

CareNet's asthma program is based on treatment guidelines developed by the National Heart, Lung and Blood Institute. The program uses educational materials, targeted reminders, and nurse case management to improve members' levels of control. In some cases, respiratory therapists are sent to members' homes to help them with environmental assessment and education. **In 2003, CareNet's rate of members receiving appropriate medications (as defined by HEDIS) improved by over 20%.**

The 2004 HEDIS measurement for use of appropriate medications for people with asthma exceeded the National HEDIS Medicaid rate of 64.1%. **Four of the five MCOs surpassed the National HEDIS Medicaid rate.** The remaining MCO missed the national benchmark by only 2.2 percentage points.

Figure 7. HEDIS 2004 Asthma Medication Appropriateness by MCO



Provider Networks and Recruitment

The hallmark of Medicaid managed care is the relationship of Primary Care Providers (PCPs) and Medicaid recipients. The ratio of PCPs available to Medallion II enrollees has remained fairly stable and translates to greater access and utilization for individuals in managed care organizations. Each MCO focuses on provider recruitment and network development in their operations to ensure that networks meet or exceed DMAS' recipient-to-provider ratio requirements.

Figure 8. Medallion II and FFS Recipient-to-PCP Ratios

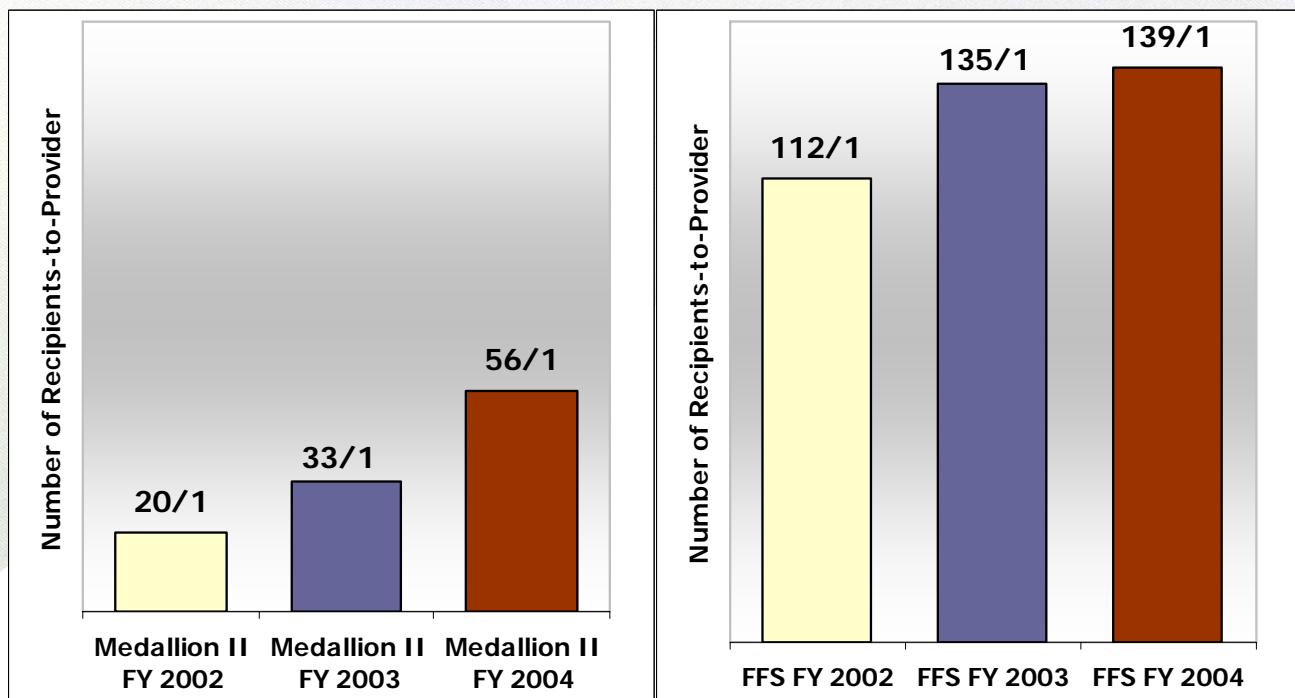


Figure 7 displays the Medallion II recipient-to-provider ratios as compared to FFS. The increase in recipients to PCP provider increased for both programs. However, the increase was lower in the Medallion II program. The ratios are indicators of access to care.

Access to Care

Access to care in the provider networks is excellent according to the number of open PCP panels. The majority of the MCOs and MEDALLION have open or restricted panel slots at or above 70% of their total panels. The only area of concern for the Managed Care Unit has concerns is the Fredericksburg, Stafford, King George, and Spotsylvania region. This area is being closely monitored.

24-Hour, 7-Day Accessibility to Care: MEDALLION and Medallion II Programs

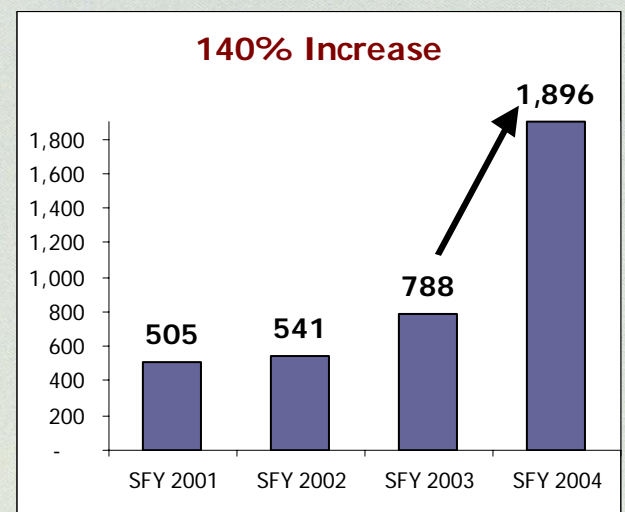
This 2003 report summarized the results of the second survey of 24-7 access to care for participants in the MEDALLION and Medallion II plan. The ability to reach one's provider outside of normal office hours is critical to both patients' quality of care and to efforts to manage costs incurred for Medicaid recipients' medical care. **Ninety percent of providers in the MEDALLION sample and 89% in the Medallion II sample had valid phone numbers that were answered within six rings. In addition, 93% (MEDALLION) and 87% (Medallion II) provided information regarding who to call or how to access services in an emergency.**

One of the most significant findings in this study was the substantial improvement in rates of reaching valid provider phone numbers with appropriate emergency contact information. **The number of valid phone numbers for both MEDALLION AND Medallion II providers increased from about 70% in the previous year's study to 90%.** Each MCO's rate of emergency phone access information was higher than the rates reported for both MEDALLION and Medallion II in the previous study. It appears that all the MCOs are progressing with respect to the phone access to care available to their members.

Provider Relations

The MEDALLION program saw successes during the past fiscal year as staff concentrated on increased communication and education to providers and stakeholders. **Nearly 1,900 MEDALLION PCPs were visited to assess compliance with Virginia Medicaid rules and MEDALLION Agreement regulations. This represents a 140% increase compared to the last reporting year in which staff in the Managed Care Unit visited approximately 800 PCPs.** Additionally, local hospitals were provided courtesy visits in order to supply admission and utilization review departments with a Managed Care Resource Guide, comparison charts, and brochures regarding Virginia's Medicaid managed care programs.

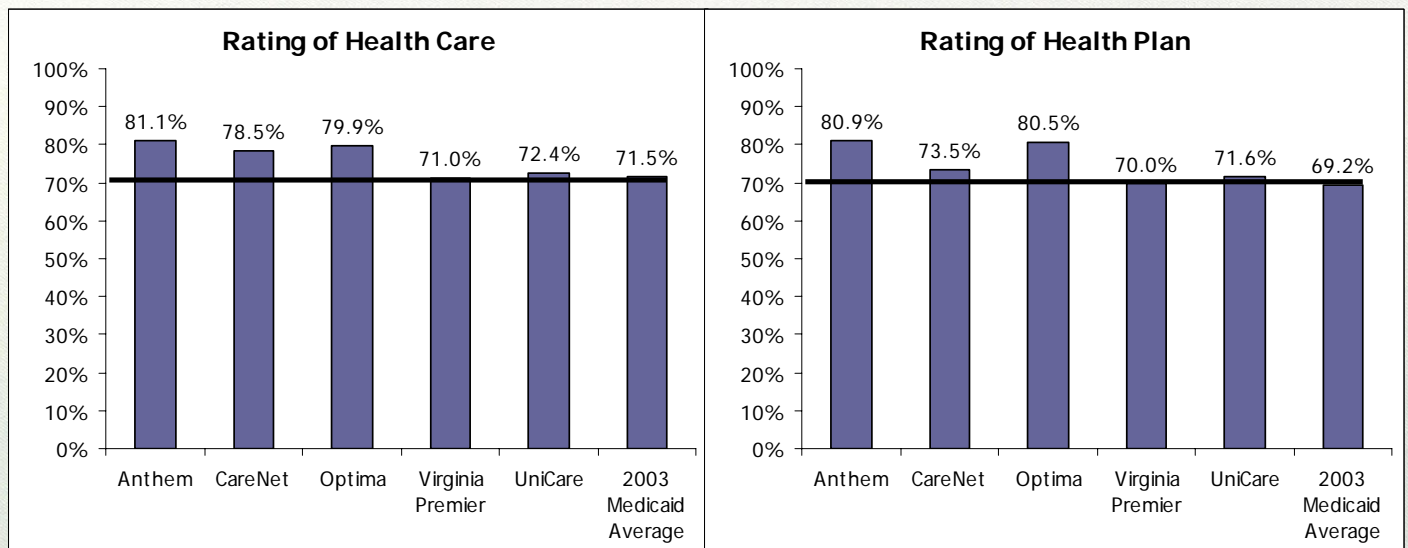
Figure 9. Comparison of DMAS Staff Visits to MEDALLION PCPs in 2001 - 2004



The Consumer Assessment of Health Plans Survey (CAHPS) for Medallion II

The Consumer Assessment of Health Plans Survey (CAHPS® 3.0H) provides consumers, purchasers, and health plans with information about a broad range of key consumer issues such as overall satisfaction, average wait times, physician availability, obstacles to receiving care, and parents' impressions of their children's care. The purpose of patient satisfaction studies is to provide an MCO's management with continuous feedback about their members' experience with medical facilities and medical service providers, including scheduling, access to providers and specialists, wait times, and quality of clinical interactions. The HEDIS/CAHPS survey can function as "scorecards" promoting accountability and better management.

Figure 10. CAHPS Results for Medallion II Adults – Ratings of Health Care and Health Plan by MCO

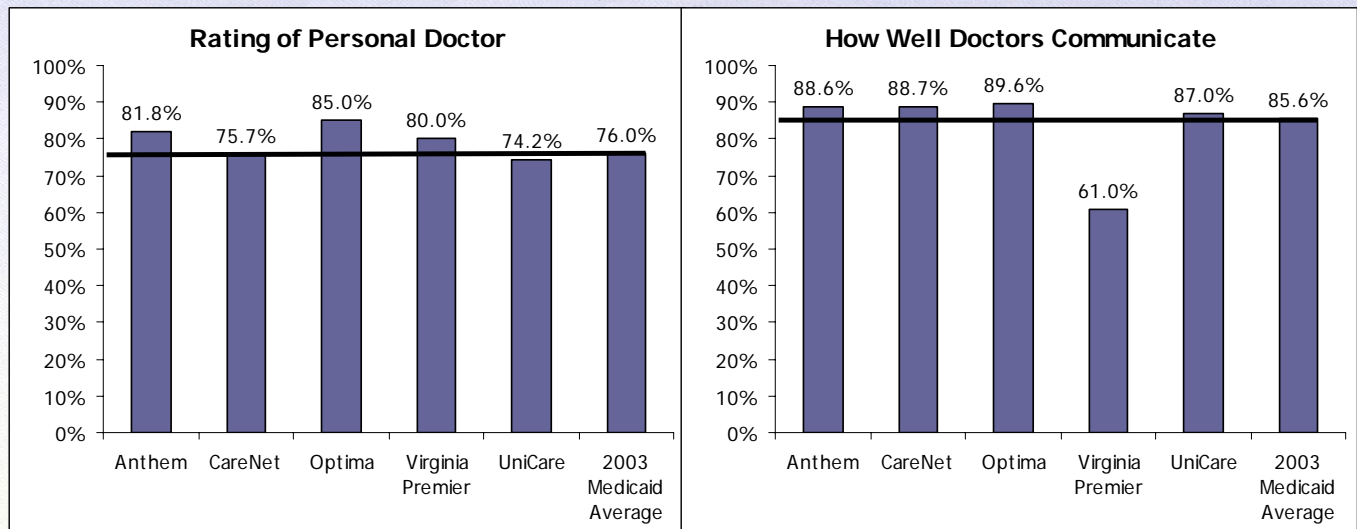


Members were asked to rate various health care experiences by providing an overall evaluation on a scale of "0 to 10", where a "0" means worst possible and a "10" means best possible. 2003 Medicaid Average is the national CAHPS® 3.0H benchmark results taken from NCQA's Quality Compass®.

During SFY 2004, the MCOs participated in the survey for its adult members 18 years of age or older. **Nearly all the MCOs exceed the National 2003 Medicaid average rating (71.5%) when evaluating the quality of their health care. Similarly, every MCO exceeded the 2003 National benchmark of 69.2% when rating the quality of their health plan.**

The Consumer Assessment of Health Plans Survey for Medallion II

Figure 11. CAHPS Results for Medallion II Adults – Personal Doctor and Doctor's Communication



Members were asked to rate various health care experiences by providing an overall evaluation on a scale of "0 to 10", where a "0" means worst possible and a "10" means best possible. 2003 Medicaid Average is the national CAHPS® 3.0H benchmark results taken from NCQA's Quality Compass®.

Members in each MCO rated their personal doctor at or above the National 2003 Medicaid average of 76%. Only one MCO rated lower than the 85.6% 2003 National Medicaid average when asked to rate how well doctors communicate.

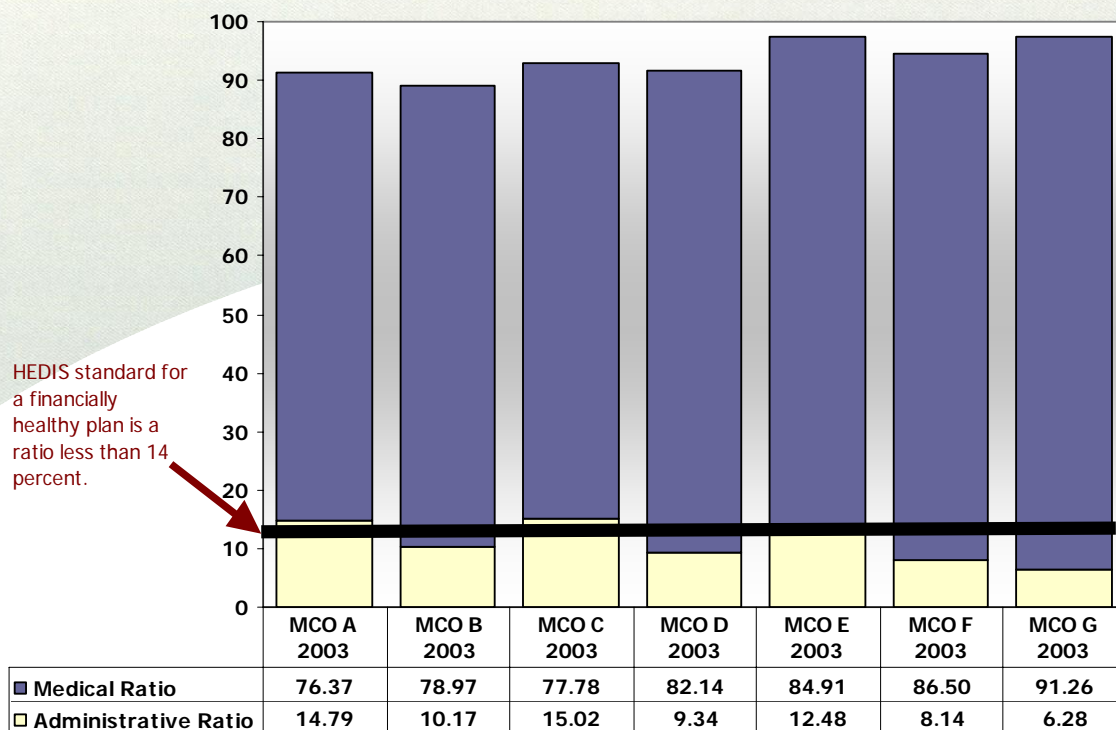
MCO Financial Solvency

The Virginia Bureau of Insurance licenses MCOs operating within Virginia. The licensing process ensures financial solvency. For the purpose of this report, DMAS focuses on two measures of financial solvency: administrative and medical cost ratios. HEDIS establishes the industry standards for measuring quality performance of MCOs.

- The Administrative Cost Ratio is the percentage of each dollar paid to the MCO that is spent on administration (e.g., salaries, offices, rent). The HEDIS standard for a financially healthy plan is a ratio of less than 14 percent.
- The Medical Cost Ratio is the percentage of each dollar paid to the MCO that is spent on medical care.

Individual financial information on the contracted managed care organizations is available on the Virginia State Corporation Commission Bureau of Insurance web site. This information can be accessed at: <http://www.state.va.us/scc/division/boi/webpages/boifaq2c.htm>.

Figure 12. MCOs' Administrative and Medical Cost Ratios – Annual 2003



Based on the annual 2003 financial reports provided by the MCOs to the Cost Settlement and Reimbursement Division, the Medicaid MCOs appear to manage their debt well and appear financially sound, profitable, and solvent. There has been improvement in the administrative cost ratios for various MCOs in 2003. The above ratios reflect filings for all business segments of the MCOs, both commercial and Medicaid.

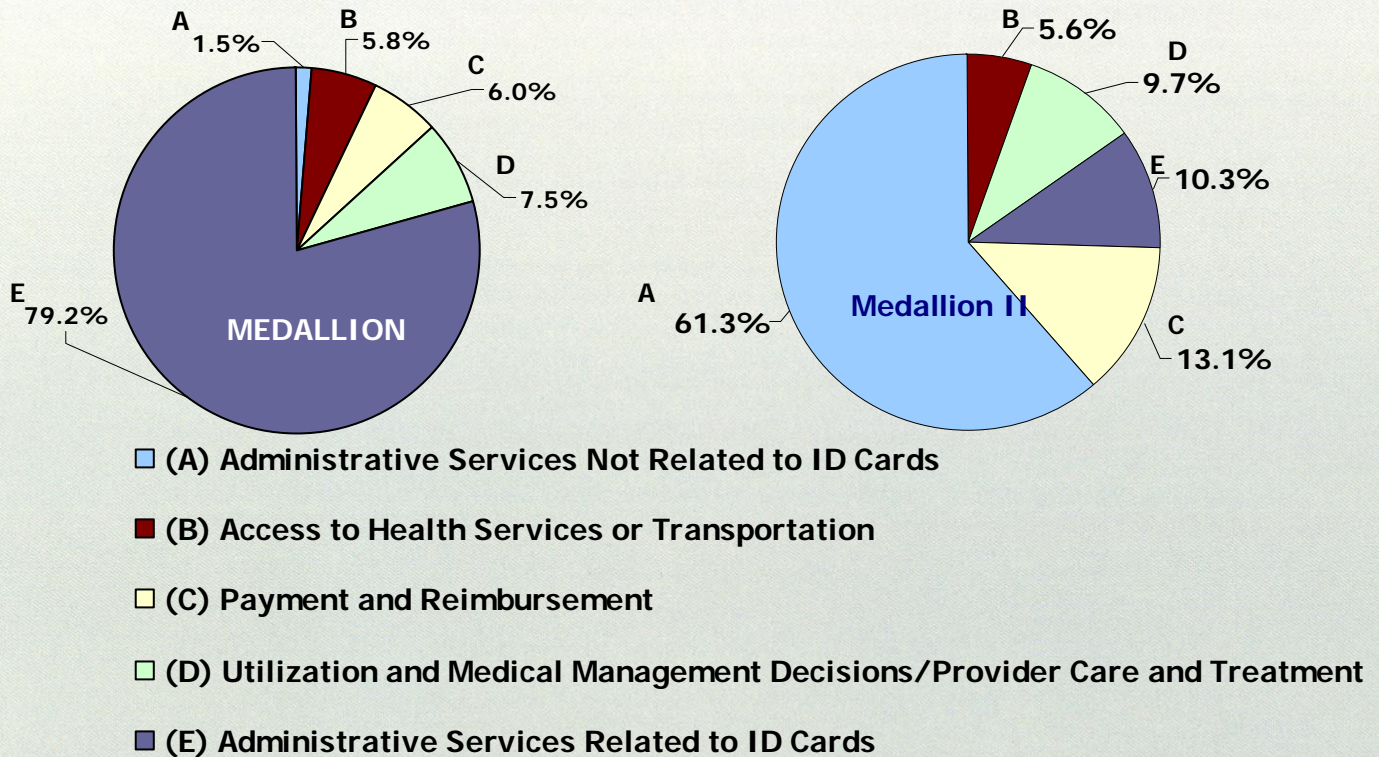
Note: Anthem HealthKeepers Plus by Peninsula Health Care, and Anthem HealthKeepers Plus by Priority Health Care's results are reported separately.

Monthly Monitoring Reports

The Division of Health Care Services prepares monthly monitoring reports on PCP panel size, paid claims, appeals, and complaints. Complaint categories tracked by DMAS include average monthly complaints per 1,000 recipients for the following categories:

- Access to Health Services,
- Access to Transportation Services,
- Utilization and Medical Management Decisions,
- Provider Care and Treatment,
- Administrative Services Quality,
- ID card, and
- Payment and Reimbursement.

Figure 13. Percentage of Complaint Types to Total Complaints by Managed Care Program



FAST FACTS: Complaints

- Monthly complaints for MEDALLION were 1,102 representing 1.1 complaints per 1,000 enrollees. The majority of complaints were issues that arose concerning ID cards; however, LogistiCare, the transportation vendor for FFS and MEDALLION, does not report by program resulting in transportation complaints being under-reported for the MEDALLION program.
- Medallion II had 6,701 complaints, a decrease of 16% from last year, representing 1.9 complaints per 1,000 Medallion II enrollees. The majority of this program's complaints involved inquiries dealing with transportation issues.

Conclusion

DMAS is committed to continually enhancing our partnership with the Medicaid providers, case managers, client advocates, outreach workers, and the Medicaid contracted Managed Care Organizations to ensure continuity of care to individuals. Managed care has been a key focus of the Department's work.

MCOs provide a variety of both administrative and clinical services to the Department and program recipients that go beyond those provided in Medicaid fee for service programs. These enhanced services are being expanded across the agency in an effort to ensure that all Medicaid clients receive high quality, comprehensive health care.

This commitment is demonstrated in the following activities:

- Expansion of Managed Care to new localities in 2005 and 2006.
- Implementation of a new dental program. DMAS, in collaboration with the Virginia Dental Association (VDA), is proud to announce a new dental program called ***Virginia Smiles***, targeted to begin in July of 2005;
- Implementation of the FAMIS MOMS program, which increases the income standard for pregnant women to 175 percent of the federal poverty level;
- Implementation of new pharmacy programs such as the Preferred Drug List, Maximum Allowable Cost (MAC) program, Threshold (a program is designed to identify recipients at higher risk for medication-related adverse events based on the number of prescriptions received in a thirty-day period,) and a Coordination of Care Program;
- Implementation of a new transportation program modeled after the MCOs;
- Development of new materials for children about the EPSDT program; and,
- Development of an annual report by the Division of Long Term Care and Quality Assurance.

Capitation payments to the contracted health plans were over \$900 million for the past year. This amount is one-fourth of Virginia's Medicaid budget; however, the health plans provide services to over 60% of the individuals in Medicaid, of which the majority are children.

Even though the managed care programs provide a high-quality health care for the Commonwealth and the individuals enrolled in managed care, there is always room for improvement. During the past year, the direction provided by the ED2 solidified our efforts to promote our number one objective, child health. Stated simply "The way to have healthy children is through a health pregnancy." It is anticipated that future resources will be focused to help insure the continued success of this objective.

Further, more than ever before, the influence, expertise, and vast resources available to our MCOs are being shared with other Virginia Medicaid programs. We hope to continue to rely on the MCOs to share their "best practices."

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